MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
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COMMISSIONERS PRESENT:

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AGENDA ITEM: Options for changing the Medicare benefit package -- Anne Mutti, Ariel Winter

Now we're moving on to the discussion of options for changing the package.

MS. MUTTI: In this presentation we discuss an array of policy options that would address some of the problems that we've identified in earlier presentations with the current Medicare benefit package. As consistent with your conversation just before this, we're not making draft recommendations for you but instead laying out some of the pros and cons of the different approaches and some of the design questions that you might need to consider.

We have organized these policy options into three categories that are progressively more fundamental in their degree of reform. As you can see up on the screen, the first is potential cost-sharing changes. These changes preserve the basic structure of the program while addressing problems such as the lack of protection from high out-of-pocket costs and uneven cost-sharing requirements that can result in inappropriate use of services.

We then consider additional benefits that could be added to the Medicare benefit package. Specifically we present options on prescription drug, case management, preventive services, and long term care issues.

Finally, we address a notion that I think has become familiar to you now. We call it fundamental reallocation of resources among existing payers. Where beneficiaries would be offered a single comprehensive benefit package that would reduce their demand for supplemental insurance, which as we have indicated has introduced numerous inefficiencies in current total spending for beneficiaries. So in theory, under this approach the savings gained from eliminating the inefficiencies would offset the costs associated with a comprehensive benefit package.

Now for the remainder of the presentation we're planning to go through each of these categories and give you a sense of the array of options we have identified and the types of issues we plan to discuss. We are looking for your feedback on whether you are comfortable with the categorization of our options, the range of options themselves, whether we have identified the key design considerations, and what level of detail you would like us to go into, especially given our time constraints.

At this time then we'll begin with cost-sharing changes and Ariel Winter will present.

MR. WINTER: Thank you. First I would like to review the goals of cost-sharing in health insurance design. Cost-sharing should be low enough to provide financial protection against high medical costs and facilitate access to care, but it should be high enough to discourage use of services of marginal value. Cost-sharing should be lower for less discretionary services such as inpatient hospitalizations and most price sensitive discretionary services such as physician visits.

Using these principles as a guide, Medicare's current cost-

sharing structure is less than optimal. It imposes high cost-sharing on inpatient hospital and outpatient hospital services, for example. It requires fairly low cost-sharing on many Part B services, and it does not provide a catastrophic cap on beneficiaries' total liability.

I'm going to discuss how this cost-sharing structure could be changed to accomplish three objectives: to improve beneficiaries' financial protection from high medical costs, to reduce financial barriers that limit access to care, and to provide better incentives to control the use of price sensitive discretionary services.

First, changing Medicare's deductible requirements could help accomplish these goals. Currently, the program has an inpatient hospital deductible of $812 per spell of illness and an annual Part B deductible of $100. This structure imposes high costs on those with hospitalizations and provides weak incentives to control the use of Part B services. To address these concerns, policymakers could consider raising the Part B deductible, lowering the Part A deductible, or doing both in combination.

Second, policymakers could consider making changes to Medicare's coinsurance rules to improve protection from high out-of-pocket costs, especially for less discretionary services, and increase cost-sharing on more discretionary services. These options could include eliminating the hospital coinsurance for days 61 to 150 of a hospital stay, requiring cost-sharing for home health services and clinical lab services, modifying the skilled nursing facility coinsurance, reducing outpatient hospital coinsurance, reducing mental health outpatient coinsurance, and eliminating coinsurance on preventive services.

Third, policymakers could consider adding a cap on out-of-pocket spending for covered services. This approach would help protect beneficiaries against high medical costs, and depending on the level of the cap, may encourage some beneficiaries to forgo supplemental insurance.

That brings us to the last type of change that we consider here, which is altering the type of coverage offered by supplemental insurance. As we discussed yesterday and today, supplemental insurance covers most cost-sharing, which reduces financial barriers to care, but also induces beneficiaries to use more services by making them less sensitive to their cost.

One option to consider is encouraging supplemental insurers to reduce coverage of first dollar costs, such as the Part B deductible, and adding a cap on high out-of-pocket costs. The Administration's proposed new Medigap plans K and L would include these features.

To get a sense of how these cost-sharing options could be combined to achieve different objectives we have developed five packages that illustrative different combinations of changes. I want to stress, these are just illustrative changes. There are many other changes you could consider as well.

At the far left of the table are the cost-sharing features we've changed in some or all of the packages. The first column shows current law. The next five columns show the changes in

each package. And the bottom row displays approximate 2002 cost of each package to give you a sense of what can be done at different spending levels. We've not done five, 10, or 30-year estimates; just a one-year estimate to give you a sense of the magnitude of the change.

Option A, as you can see, would be about budget neutral. Options B and C would cost in the range of $4 billion to $5 billion. And Options D and E would cost about $9 billion in 2002. These costs come from a model developed for us by Actuarial Research Corporation which I can give you further details about if you'd like.

Option A would replace the separate Part A and Part B deductibles with a combined annual Part A and B deductible of $400. It would also eliminate copayments on inpatient days beyond 60, and eliminate limits on the number of covered days per stay. This combination would provide more complete inpatient hospital coverage. This improvement in hospital coverage would be financed by higher deductible on Part B services which improve incentives to use Part B services prudently. If supplemental coverage were to respond by covering the combined deductible then we would expect smaller efficiency gains.

Relative to current law, the 20 percent of beneficiaries with inpatient hospital use would have lower cost-sharing while the 70 percent of beneficiaries who currently spend over $100 on Part B services would face higher liabilities. To the extent demand for supplemental coverage is motivated by the currently high Part A deductible, this change could reduce demand for supplemental coverage. However, higher deductible on Part B services could increase demand.

Option B would add a $5,000 cap on out-of-pocket spending on Medicare covered services. About 3 percent of beneficiaries would reach this cap. We estimate that this option would increase costs by about $5 billion. If we restricted Medigap from covering the combined deductible we expect that use of services would decline due to greater price sensitivity and the cost of this package would be cut in half.

Option C would do two things. It would add a home health copayment of $10 per visit capped at $200 in total per episode, and it would replace the current skilled nursing facility copayment on stays beyond 20 days with a copayment of $25 per day for all days of the stay. Adding a modest cost-sharing to home health services would improve incentives for beneficiaries to use home health appropriately. It would also save the program almost $2 billion in 2002 which would help offset the cost of other changes. As an aside, the Commission recommended a modest home health copayment in its 1998 report.

Imposing copayments on the entire SNF stay and reducing the copayment per day would have three main effects. It would improve equity, because all SNF residents would share in the cost, not only long stay residents. It would reduce the financial burden of longer stay SNF residents. Under the current system, beneficiaries who incur any copayments -- that is those with stays of over 20 days -- incur total average cost-sharing of about $3,000 which would fall to about $1,200 in this approach.

Finally, shifting cost-sharing from the last 80 days of a stay which are the most discretionary days, to the first 20 days which are the least discretionary, would reduce incentives to control the use of SNF services.

When considering a home health or a SNF copayment it's important to keep in mind that these services are in some cases substitutable. So you don't want to encourage beneficiaries to choose SNF or home health on the basis of which one has no cost-sharing. That's why we structured both of them to have copays on the initial visits or days.

The SNF copayment change would increase cost by about $1 billion. So the total cost for this option is about $1 billion less than Option B.

Option D would make three changes. It would reduce the out-of-pocket cap to $3,000; about 8 percent of beneficiaries reach this cap versus 3 percent of beneficiaries who would reach the higher out-of-pocket cap of $5,000. It would eliminate cost-sharing on currently covered preventive services that require coinsurance to encourage greater use of preventive services. And it would reduce coinsurance for outpatient mental health services from 50 percent to 20 percent.

Currently, Medicare discriminates against beneficiaries on the basis of their illness by charging higher cost-sharing for outpatient mental health services than other services. Equalizing the coinsurance rates would ensure parity of coverage and improve access to mental health care. Relative to Option C, , lowering the out-of-pocket cap more than double the cost to $9 billion.

Option E is essentially the same as Option D but we return to the $5,000 out-of-pocket cap and we add a buydown of outpatient hospital coinsurance to 20 percent of the total payment amount. Currently the coinsurance is closer to 50 percent of the payment. The Commission has previously recommended that the buydown be accelerated to reach 20 percent by 2010.

This would reduce the financial burden on beneficiaries who use outpatient services and it would equalize coinsurance across different sites of outpatient care, reducing financial incentives to choose one site over another. This option would also cost about $9 billion because the cost of the outpatient hospital buydown is about the same as reducing the out-of-pocket cap from $5,000 to $3,000.

The bottom line is that one could change the cost-sharing structure to improve financial protection, reduce financial barriers to care, and improve efficiency. Some changes could be done in a budget neutral fashion but others would require some additional spending, such as the out-of-pocket cap and the buydown of outpatient hospital coinsurance. In addition, restricting supplemental insurance from providing full first dollar coverage would reduce Medicare spending and produce savings that could be used to help offset the cost of new benefits.

So that's what we have for the cost-sharing changes.

MR. MULLER: I was wondering, what's $100 of deductible

worth in billions? So if it were $500, $600, $700, what's that worth in billions?

MR. WINTER: I'm not sure. I can do a quick calculation and get back to you on that.

DR. ROWE: What's the denominator? When we're looking at $9 billion what's the denominator?

MR. WINTER: $9 billion would be about 4 percent of total costs, 4 percent increase above current cost which are about -- in this model they're about $268 billion. But with the new estimates coming out they would lower it to about $250 billion so the percentages would change.

DR. REISCHAUER: This is all quite interesting, but I would love to see another line in here, and I don't know if Jim can produce a line like this. That is, how much of a reduction in a Medigap premium would this represent? By doing that you would take the actuarial value, add the loading factor, multiply by 100 percent of the beneficiaries and come up with a billions of dollar number, because that's really the comparison we should be making here. So that would be one sort of, if we could do it, it would be nice.

The second question I'd ask is, why, or did you, in addition, estimate what elimination of the three-pint blood -- I don't know whether you call it the deductible draw or what. It strikes me as one of the more bizarre characteristics of the Medicare program. And why not coinsurance on lab fees?

MR. WINTER: Let me first address the question about the premium. We did convert the increase in Medicare costs into what it would be for a per-beneficiary premium. That would range from about, for the B and C about $120 per year versus about $240 per year for Options D and E. But we can look into how that would play out in terms of the Medigap premium. We did not calculate eliminating the deductible on blood. We can look into that.

We thought if we considered adding a coinsurance or applying the Part B coinsurance to clinical lab services we could go ahead and model that. We decided not to for this round because the coinsurance amounts, because the cost of the services are so low, the coinsurance would also be very low, and the cost for the lab of billing that beneficiary for that coinsurance might exceed the amount they would be collecting.

DR. REISCHAUER: I must be going to the wrong labs.

MR. WINTER: That's at the average. But there are certainly services that would cost a lot where the coinsurance would be more. The other factor we considered was that beneficiaries have lower control over the labs that are ordered on their behalf than on physician visits or other services. But we could still go ahead and model that for you.

MS. ROSENBLATT: I liked this chart, although I think it would be much better if we added some of the other metrics that have been suggested, like Jack's percent, and Bob's premium impact. I guess I'm confused with the -- I like the idea of the combined deductible, but how do you deal with that in terms of the funding issue between Part A and Part B? When you're saying it increased the premium, how did you deal with that issue?

Then I've got another suggestion. Since you're only dealing

with a one-year view, my suggestion would be that anywhere you've got dollar amounts like $400, $10 a visit, $25 a day, index them, so that when you're describing it you're describing this as indexed numbers. This is what it would be in 2002 dollars. They would change. But I would like that A versus B question answered.

MR. WINTER: Those are both good points and we'll consider the indexing question.

We did think about how this would impact Part A versus Part B because obviously doing combined deductible would shift costs from Part B to Part A. Part A would assume more because beneficiaries would pay less of a deductible. We did not model how that would affect the underlying financing because there are ways in which you could conceivably keep Part A whole by having Part B pay some money back into Part A to offset its reduced costs under this combined deductible approach.

In terms of the premium amount that I was talking about would reflect how much the beneficiary would have to pay to absorb all of the costs of these changes, regardless of whether the costs were -- they were compensating the Part A trust fund or the Part B trust fund. So the premium doesn't mean that that would be the additional Part B costs alone. It would be absorbing both the Part A and the Part B additional costs.

MS. ROSENBLATT: I just think when we lay this out we've got to describe all that. You just reminded me there's another issue connected to that which is the overall out-of-pocket cap also is an A versus B issue. I may not know it, had to deal with it, but it would seem to me that that's a true operational feasibility issue. I think it would be very, very difficult to administer.

MR. WINTER: Yes. That's a good point.

MR. HACKBARTH: The A versus B issue is clearly an important one from a variety of different perspectives in terms of the financing implications, in terms of committee jurisdiction and a whole lot of different ways.

Having said that, one of the things that I liked about Bob's suggestion that we think about this exercise in terms of starting anew is that it allows us to remove ourselves from those constraints. I think we need to acknowledge that they are real world issues, but I would prefer that we not say, this is an immutable constraint that we've got to accept and can't look at options in this way. I think we'd start to tie ourselves in knots.

DR. ROSS: Just to follow up on that point. That split is no longer anywhere near as clear as it was even four years ago because in BBA the law transferred a good chunk if home health spending arbitrarily from A to B. We throw around the term of 25 percent Part B spending. It's actually not quite that, it's 25 percent of estimated spending for the aged. It doesn't include the disabled.

So on these kinds of numbers I was encouraging staff to sort of round to the nearest $10 billion, so don't look for too much precision here. We're trying to give you the flavor of what you can get, and what kinds of things trade off at, if you will, hand-waving levels of equality. If you want to buy down this,

here's the right order of magnitude to pay for it.

MR. HACKBARTH: Again, our mission in this report is not to identify the right answer but rather to illustrate possible directions.

DR. NEWHOUSE: I don't think what I'm about to say would change the first significant digit on the cost number but we can do this and I think it might be nice to do it, which is to estimate the Medicaid cost, either up or down, including the federal share here. So that implicitly when we say cost I think we want to say cost to the federal budget.

DR. REISCHAUER: But if we're saying that, the costs are much lower because Medicaid saves a whole lot.

DR. NEWHOUSE: I understand. That was my point. It's not totally clear because some of the cost-sharing stuff will throw back onto Medicaid costs. But I think that's how it will come out, and I think it probably won't change anything or maybe just $1 billion. But somebody could easily raise that issue.

DR. ROSS: If you knew how Medicaid offsets were really estimated you wouldn't make that request.

DR. NEWHOUSE: Sounds like if anybody should do it we're the people that should do it then.

MR. HACKBARTH: Any other questions or comments about this table? If not, Anne?

MS. MUTTI: We'll just move on to talk about the next two categories of options. The very next one is expanding the array of services covered by the benefit package. Each of these options has the potential to increase access to care, although benefit design would influence how actually benefitted. In most cases additional benefits will add costs to the program, although the first one we'll discuss, case and disease management, has the potential to reduce program costs.

Both case and disease management seek to coordinate care for those who are at risk of needing costly medical services, many of whom are chronically ill. They seek to improve quality and reduce costs by encouraging adoption of evidence-based practices, educating patients on managing their condition, and improving access to support services.

They differ in their emphasis and their target population. Case management programs tend to focus on fewer but more diverse patients who are medically and/or socially vulnerable while disease management tend to serve greater patients with more similar clinical needs. Interventions, therefore, tend to be highly structured and emphasize use of standard protocols.

While these programs have been successful in the private sector, it is not certain that they can be equally effective as part of fee-for-service Medicare. There was a recent Medicare demonstration on case management and the results of that found that it neither improved quality or reduced costs. CMS is required by law to implement two more demonstrations in this area in fee-for-service Medicare, but these results will not be available for several more years.

Among the issues that we identified that would need to be resolved if integrating this benefit in Medicare are how best to align payment incentives among providers so that they have the

incentive to select those who would most benefit from this program and offer the most cost effective services.

It would also need to be resolved whether it's necessary to include additional benefits in the case management program such as reduced cost-sharing or prescription drug coverage. Although these additional benefits may improve patient compliance with treatment protocols, the cost of them may more than offset the savings achieved from better management and may be replacing existing private resources rather than filling a coverage gap.

Another issue is how to overcome objections that some beneficiaries who are not selected to participate in this program may have on the grounds that they are unfairly excluded from receiving additional services, be it educational counseling on how to manage their condition or prescription drug coverage. Another issue is how to manage this type of benefit on a national basis, and as was mentioned yesterday, how to link payment with patient outcomes, if that's another desired goal.

The second type of option under this category is preventive services. In the draft that we've given you so far, rather than discussing the merits of covering each new type of service or screening or program, we have focused on improving the process for making these determinations.

There's widespread agreement that the current process does not rationally direct limited resources, so the alternatives that talked about are basing Medicare coverage decisions on recommendations by the United States Preventive Task Force, which takes a much more clinical approach to assessing the evidence than is currently done, or changing statute to eliminate the general exclusion on coverage of preventive services not expressly covered by law, and therefore allow consideration for coverage of preventive services to be evaluated in the same manner as all other medical procedures and services for coverage.

Next among the options is long term care. Long term care is an obvious and intentional omission from the current benefit package that could be reconsidered. At this point, however, we are noting that there is a problem and identifying a range of potential options. But given the magnitude of resources required to address this problem and the limited available resources we have not fully fleshed out any of our options.

But we do recognize that there's a range, a spectrum of options that could be pursued from incremental to more fundamental, from those that rely on private sector solutions to those that rely more on public insurance. An example of incremental would be pursuing programs like the PACE program where Medicare and Medicaid financing can be joined and pooled in improving care management incentives.

Another option is to focus on encouraging middle and upper income beneficiaries to purchase long term care insurance. This could be pursued through tax incentives or perhaps more creative measures. For example, you could create a program where beneficiaries could opt to trade in their Part B home health benefit for Medicare coverage of catastrophic long term care costs and beneficiaries would fill in their more immediate long term care needs through private insurance. There's certainly a

lot of tradeoffs with any of these proposals and we would briefly mention them.

Perhaps the most sweeping change would be to add a long term care benefit to Medicare. As with any new benefit, design would have a big impact on costs and who benefits. And to contain costs, policymakers may opt for a higher deductible design.

The last additional benefit we discuss is prescription drugs, and that brings us to the next slide. There are three main approaches that we identified to addressing the most commonly cited limitation of the Medicare benefit package. Policymakers can add a prescription drug benefit to the benefit package, they could pursue alternative policies to expand access to drug coverage, or they could pursue approaches that reduce drug prices faced by beneficiaries, particularly those without insurance coverage.

We plan to discuss in somewhat of an abbreviated format some of the design issues that need to be resolved in adding a prescription drug benefit. In June of 2000, MedPAC did a report that went into greater depth on some of the design questions and we plan to refer readers to that rather than reiterating some of those issues.

But at a minimum, we certainly hope to make it clear that even if all parties could agree on the exact number that they wanted to devote to prescription drug spending that there are a lot of fundamental issues that need to be resolved underneath that number, including whether the benefit should be voluntary or mandatory, whether the benefit should be subsidized. If so, how? Who should administer the benefit, and how it should be administered. Like what drugs should be covered, what tools should be available to contain the costs. Those are all important issues that would have to be addressed.

If for a moment we can flip to the next slide you can get a sense of the rough cost of adding a drug benefit. Again, some of the same caveats about the estimates apply here as with Ariel's numbers. For the purposes of this illustration we have made a number of simplifying assumptions: enrollment is mandatory; management of the benefit is not particularly aggressive; beneficiaries pay 50 percent of the premium; and all three options include similar subsidies for low income beneficiaries.

The three options differ in the extent of coverage and cost-sharing design and reflect some of the proposals being considered by Congress. The light, sort of striped section, is what Medicare covers, and then the darker is what is left as the beneficiary liability. Package A reflects a design that offers first dollar coverage and would provide tangible benefits to nearly all beneficiaries. Under this design Medicare covers 50 percent of the first $3,000 of drug spending. While all of these estimates assume that improved drug coverage will increase the use of drugs, this design in particular is expected to induce greater use of drugs.

Package B is more catastrophic in design with a $500 deductible. Many beneficiaries will not have Medicare pay for any of their drug costs. But for those who have higher drug spending, they will have significant coverage, particularly the

more they spend. Between $6,000 and $10,000 Medicare pays 75 percent of their costs, and over $10,000 Medicare pays all of their drug costs.

Package C is a mix of the first two approaches. It has a relatively small deductible of $250, covers 50 percent of costs between $250 and $3,000, and then leaves beneficiaries bare until $7,500 is spent, after which it covers all of their costs. In a sense, this option provides a little bit for everyone.

As you can see from the line down toward the bottom, none of these options come cheap. Monthly premium estimates range from roughly $30 to $50, and the cost to the program is between $15 billion to $24 billion in 2002. In part this high cost is one reason that policymakers are considering two other options or two other types of approaches listed on the previous slide. They could be pursued in tandem with an integrated Medicare benefit, as an interim step, or as an alternative.

Just briefly on the other two approaches, alternative policies to expand access to drug coverage include expanding Medicaid eligibility for drug coverage to more low income beneficiaries, federal grants to states to expand their state drug programs, and restructuring the Medigap market so that plans could offer better prescription drug coverage while avoiding the adverse selection problems they experience today.

Achieving this objective may be possible if all plans are required to offer the same drug coverage, offsetting the higher cost of this benefit by reducing other coverage. For example, some of the first dollar coverage that has led to some of the inefficiencies we've mentioned earlier.

The third approach is to reduce drug prices faced by beneficiaries. This approach is exemplified by drug discount card proposals, policies to reduce the period of exclusivity for brand name drugs, and allowing drugs currently dispensed by prescriptions to be sold over-the-counter.

We come to the third category of options by asking the question, is there a better way to allocate current total resources spent on beneficiaries' health care.

MR. HACKBARTH: Anne, before we go on to that, would it make sense for us to stop and allow for questions or comments about the preceding material?

DR. ROWE: I have a question on the prevention. I think it's really a contribution to highlight this, as we spoke yesterday a little bit, this difference between what Medicare covers in prevention and what the U.S. Task Force recommends.

In the material that you wrote though you pointed out a couple areas in which these differences exist, and one is in cholesterol measurements. I guess the U.S. Task Force probably recommends that and Medicare doesn't pay for it. But I'm not sure that the U.S. Task Force recommends it for old people. They may just recommend it in general. I personally don't believe that cholesterol is a very effective predictor of cardiovascular disease in late life so I'm not sure that --

I would just clarify somehow that we would look for an objective group to provide recommendations relevant to the Medicare population. Of course, there are 5 million disabled

Medicare beneficiaries that are not elderly, but I think we want to make sure that if we're turning to an objective group, that that group should be giving recommendations relevant to our population.

The second thing is I'm a little concerned about the medical specialty societies as the group that would be recommending whether certain services would be covered. You include that, and we are, of course, always interested in their opinion, but I'm not sure that I would characterize that necessarily as an objective professional group in all instances. So I'd like to see us not include that group.

MS. MUTTI: In terms of that group, you're saying the United States Preventive Task Force?

DR. ROWE: No, the specialty societies. I mean the American College of Gynecology and Obstetrics, or the American College of Ophthalmology for, you know, should LASIK surgery be covered, for instance. I just think we need not -- we'll no doubt receive their opinion and we'll take it into consideration, but I'd like us to -- we have this U.S. Task Force. It's very distinguished. It's been a long time. It's got a great track record, why not use it?

MS. ROSENBLATT: A comment on the prescription drugs. I thought it was very good that you mentioned options to reduce prices. There have been some recent example of moving stuff to over-the-counter, so that if we could expand on that as an option that would be great.

MR. HACKBARTH: Any others?

MS. MUTTI: That brings us to the third category. Perhaps the best way to open it up is by asking the question, is there a better way to allocate current total resources spent on beneficiaries' health care? In other words, could some of the inefficiencies we have identified in current spending be eliminated and that spending be redirected in a way so that, on average, beneficiaries would have improve coverage at about the same cost? Certainly, hopefully that coverage would be more assuredly available in the future than the current forms seem to be.

One approach to consider is offering a single comprehensive benefit package that would reduce beneficiary demand for supplemental coverage. If incentives worked as planned, savings could be expected as beneficiaries no longer paid for supplemental coverage that include high administrative costs, they had reduced utilization as a result of elimination of first dollar coverage, and some savings may also result from less duplication in coverage.

This is a lot of theory here that we're playing with. We're hoping to work with actuarial consultants to model how total resources might be reallocated if a comprehensive benefit package were offered by Medicare. We plan to look at a comprehensive benefit package that would include an out-of-pocket cap, a more rational deductible structure, lower cost-sharing on hospitalization and outpatient procedures, cost-sharing on home health services, and a prescription drug benefit. This is illustrative. We're happy to add a little or take away a little,

depending on what your reactions are.

Before we have done a thorough analysis it is difficult to assess the outcome, but ARC's -- that's our consultant -- current estimate of changing cost-sharing, similar to what Ariel discussed under Option D, as well as adding a drug benefit, Option B, the most expensive one that I just discussed, would result in a total spending roughly equal to current per capita spending of $11,000 per person. I hesitate to make this comparison until we have fully refined our behavioral effects and done an analysis on out-of-pocket impacts by cohorts, but it does give you an idea of whether the changes that we're talking about, is there the money in the system now or not.

There are a multitude of issues to be resolved if pursuing this type of fundamental reform and they are largely interactive. Among them are how comprehensive should the benefit package be. This was raised earlier. In order to redirect money spent on supplemental coverage toward the cost of a single benefit package it is important that the benefit package be sufficient to encourage beneficiaries to forgo their Medigap coverage and for employers to redirect the money spent on retiree coverage to offset the premiums for the comprehensive package.

It is unclear how comprehensive the benefit package has to be to induce this response. If it has to be very comprehensive with near first dollar coverage it would likely increase costs systemwide. On the other hand, if it can be somewhat more limited it could net out to be cost neutral systemwide.

Then I just wanted to offer a couple of thoughts on potential behavioral responses. It's unclear how employers will respond under this, as I have mentioned. Under the scenario, they may redirect their contribution to offset an increased premium for this new comprehensive benefit package. They would happy to be out of the business of managing health benefits.

On the other hand, they could choose to continue to offer additional wraparound because that basic benefit package, even though more comprehensive, may still not be as comprehensive as what they were offering before. Or they may take the opportunity to reduce their role in retiree health insurance, withdrawing a portion or all of their previous commitment.

Then in terms of those who have Medigap, some may choose to continue to supplement the comprehensive package. They may value the predictability of their liability, even though we have filled in a lot of the gaps. Then we also need to take into account that if the comprehensive benefit package were offered, Medigap premiums could be expected to decrease, or at least not increase as fast as would have been expected before, although these plans would be forced to spread relatively fixed marketing and admin costs across a smaller benefit which could decrease their value.

Another question is whether enrollment should be voluntary or mandatory. Mandatory enrollment solves a lot of problems but creates others. It would reduce the problematic effects of adverse selection, but it would potentially require that some beneficiaries pay more for benefits they already receive through alternative sources.

MR. HACKBARTH: Anne, you say enrollment. What are they

enrolling in under the restructured package?

MS. MUTTI: I was allowing for a scenario where you could have a comprehensive package stand side by side with the current benefit package, or you'd have it totally replace it and then it's therefore mandatory.

Voluntary enrollment invites adverse selection problems, which in turn increases costs but avoids forcing people into plans that are not to their individual advantage.

Another question is who should administer the benefit package. This comprehensive benefit package could be administered by CMS just as the current fee-for-service Medicare program is administered. On the other hand, it could be offered by private plans which could, for example, compete to attract beneficiaries or be designated regional administrators of the plan.

How would the role of government supplemental insurance be affected? Should Medicaid continue to pay for cost-sharing for low income beneficiaries or are there efficiencies to be gained by having Medicare cover these costs? What happens to eligibility for VA benefits that beneficiaries are increasingly relying upon?

And the final question that we offer up just in this quick summary, but I think there are many more to discuss in the paper, is how would the comprehensive plan by financed? As we mentioned, ideally the higher costs associated with this comprehensive plan would be offset by savings achieved by eliminating inefficiencies, and as resources are redirected from other premiums now to this single big premium.

However, a big question is whether there's any way to avoid creating winners and losers, and whether even though there could be efficiencies to be gained, the winners and losers issue could politically doom such a proposal.

MR. HACKBARTH: We know the answer to that question already. We don't have to study that one.

MS. ROSENBLATT: First of all, congratulations to staff on being real quick learners just from yesterday.

MS. MUTTI: We picked up a few things.

MS. ROSENBLATT: Absolutely, you picked up some good points. I was going to mention, Jack, my first comment is a tone issue. Once again, as I mentioned yesterday, the Medicare supplement tone issue -- and I will give you guys a copy of my underlined paragraphs where I found that tone to not be something I liked seeing.

The other issue, I was pleased to see that Jim and crew will be looking at the estimates, because there were some statements in there that increasing the basic package, and therefore decreasing the supplement, would actually save overall, and I don't know that those statements are correct. They really need to be checked out.

MR. HACKBARTH: Any other comments?

DR. NEWHOUSE: I thought we covered in the prior discussion a lot of our answers to the issues on the final slide. It may be better use of our time to ask Anne or others on the staff to say what they wanted more on of these issues.

MS. MUTTI: You feel that we actually have concrete answers to each of these questions?

DR. NEWHOUSE: For example, I think we said, or at least as I heard the Commission they wanted a comprehensive benefit package. We didn't really talk about the stand-alone versus replace, but I think the general assumption was it would replace. Who administers, I think we kind of know the answer to that one also.

MS. MUTTI: But are you comfortable with me talking about pros and cons of different ways to go on each of these questions?

DR. NEWHOUSE: Sure.

MS. MUTTI: That was what I was planning on doing. Not presenting there's one right answer on each of these.

DR. NEWHOUSE: All right, fine.

DR. BRAUN: I think there's one group of needs maybe for older folks that are not mentioned in this which are low tech, and that's vision, hearing, and dental, all of which I think grow more important as people get older.

MS. MUTTI: So then is everyone comfortable with these three categories and us describing the options in sort of a progressively fundamental reform approach? We'll acknowledge under each of these sections that they could be done cost neutrally, they could cost money, they could save money depending on how design is done. That gets at some of the other issues that we wanted to talk about too, I think.

MR. HACKBARTH: Good. Thank you. It's starting to take shape.